CHILDREN'S RESOURCE CENTER

Child Medical History

(To be completed by parent or guardian)

FOR OFFICE USE ONLY
Name of MHA Provider: ______________
Date of MHA: ______________
Date submitted to nursing: ______________
Date received by nursing: ______________

CHILD'S NAME:	DATE:	DOB:
CHILD'S HEIGHT:	CHILD'S WEIGHT:	
Check: Male Female	CHILD'S BIRTH WEIGHT:	
CHILD'S RACE: ☐ Caucasian ☐ Middle Eastern ☐ Asian or Pacific Islander	☐ Native American ☐ Hispanic ☐ Other	☐ African American ☐ Bi-racial
NAME OF PERSON COMPLETING FORM:	RELATIONSHIP TO CHILD:	

1. Family physician/pediatrician: ______________

2. Date of child's last medical office visit: ______________

   Reason for visit: ______________

3a. Date of child's last complete physical examination: ______________

3b. Date of child's last eye examination or physical examination that included an eye examination: ______________

4. Family dentist: ______________

5. Date of last dental office visit: ______________

6. Are the child's immunizations up to date? ☐ Yes ☐ No

7a. Does your child have allergic reactions to any medications? ☐ Yes ☐ No
If yes, please list the medication and describe the reaction, e.g., rash, cough, sneezing, stomach or intestinal problems, etc.

NAME OF MEDICATION	REACTION

7b. Does your child have other allergies? ☐ Yes ☐ No
If yes, please list and describe reaction, e.g., rash, cough, sneezing, stomach or intestinal problems, etc.

ALLERGIES	REACTION

8. Is your child currently taking medication **including prescription medications, over-the-counter or sample medications, herbal products, vitamins, nutriceuticals, and respiratory therapy-related drugs such as inhalers?**
☐ Yes ☐ No If yes, please list:

MEDICATION (prescription and non-prescription – see above)	PRESCRIBING PHYSICIAN or N/A	DATE STARTED	DOSAGE	HOW OFTEN	REASON FOR MEDICATION

9. Has your child taken medications for purposes of managing behavior or mood or attention/concentration?
 Yes No If yes, please list:

MEDICATION	PRESCRIBING PHYSICIAN	DATE STARTED	DATE STOPPED	DOSAGE	REASON FOR MEDICATION

10. Have there been any recent (past three months) changes in your child's medications? Yes No
If yes, please list: ______________________________
____
____

11. Has child experienced serious illnesses or injuries in his/her lifetime? Yes No If yes, please list:

ILLNESS OR INJURY	AGE OF CHILD AT TIME OF ILLNESS OR INJURY

12. Has child undergone medical operation(s) or hospitalizations in his/her lifetime?
 Yes No If yes, please list:

TYPE OF MEDICAL OPERATION/HOSPITALIZATION	REASON FOR OPERATION OR HOSPITALIZATION	WHERE	CHILD'S AGE

13. Has child ever been hospitalized for psychiatric/emotional/behavioral reasons, including substance abuse:
 Yes No If yes, where: ______________________________
Dates: from __________ to __________ Counselor's name: ______________________________

14. Did any problems occur with mother's pregnancy or child's delivery?
 Yes No If yes, please describe:
____
____

15. Has the child experienced any physical or developmental problems in his/her lifetime? Yes No
If yes, please describe: ______________________________
____

16. Describe the child's health: Good Fair Poor

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Clinician Comments:

17. In the past 12 months has your child had any of the following symptoms?

- □ Wears glasses
- □ Visual problem
- □ Hearing problems
- □ Speech/language problems
- □ Eating problems
- □ Sleeping problems
- □ High fevers
- □ Convulsions/seizures
- □ Fainting spells or blackouts
- □ Unusual tiredness
- □ Breathing problems or asthma
- □ Nosebleeds
- □ Headaches
- □ Stomach problems
- □ Sexually transmitted diseases
- □ Back pain
- □ Diarrhea
- □ Constipation
- □ Vomiting
- □ Frequent infections
- □ Soiling
- □ Daytime wetting
- □ Bedwetting
- □ Frequent urination
- □ Menstrual pain, irregular or late menstruation
- □ Heart problems

Other: ______________________________

18. Does your child complain of physical pain? Yes No
If yes, how often does this occur?(check the best answer)

1 Rarely 2 Occasionally 3 Sometimes 4 Often 5 Very Often

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Clinician's pain assessment (if 3+):	Severity:
Frequency:	Doctors' care:
Duration:	Effects on fx:

19. Has there ever been a report to police or social services about the following types of abuse toward your child? Fill in correct columns for each category:

	NO	YES	IF YES, ALLEGED ABUSER	& DATE
PHYSICAL ABUSE:				
SEXUAL ABUSE:				
EMOTIONAL ABUSE:				
NEGLECT:				

20. List physical exercise, sports, fitness activities in which your child participates regularly.
If not applicable, please circle: **None**

____

____

21. Do you have concerns about your child's eating habits? □ Yes □ No
If so, what are they? ______________________________

22. Has your child experienced a significant weight gain or loss during the past three months? ______________________________

____

23. Is the child sexually active? □ Yes □ No □ Don't Know

24. If female, has she begun to menstruate? □ Yes □ No □ Don't Know
If yes, at what age? ____________________
Has she ever been pregnant? □ Yes □ No □ Don't Know

25. Place a checkmark by any of the following substances you know that your child has used in the past. If, to your knowledge, your child has never used any of these substances, please circle: **None**

- □ Pep pills or uppers
- □ Tranquilizers
- □ Marijuana
- □ Nicotine (cigarettes, tobacco)
- □ Inhalants (butane, gasoline,etc.)
- □ Caffeine
- □ Alcohol
- □ LSD/Hallucinogens
- □ Cocaine/Crack
- □ Other, please specify: ______________________________

26. Do you or anyone you know think the child has ever had a problem with any of the substances checked above?
 Yes No
If yes, please state which substances, at what point in their life, who believes it is a problem and why, and if he/she has ever been treated for substance or drug abuse:
____
____

27. Check appropriate column for following things that child may have done or experienced. Has child....

	NO	YES	If yes, how many times & when
Repeated grade in school?			
Been expelled from school?			
Threatened suicide?			
Attempted suicide?			
Starved self?			
* Done binging or purging?			
Overdosed on drugs			
Injured self on purpose?			
Been arrested?			
Been in juvenile detention center (i.e., JDC)?			

* BINGING is the rapid, uncontolled consumption of large amounts of food.
PURGING is getting rid of food eaten during a binge. The most common method of purging is self-induced vomiting, but some turn to laxatives, fasting, severe diets, vigorous exercise and other methods to counteract a binge.

28. If applicable, have you established advance directives for your child? Yes No or Not applicable
If yes, please provide a copy.

FAMILY MEDICAL HISTORY

29. Check any of these conditions which apply to a blood relative of the child: (If checked, indicate which relative.)

CONDITION	RELATIVE (relationship to child)
☐ Hyperactivity	
☐ Learning problems	
☐ Mental illness, including depression List diagnosis if known:	
☐ Alcoholism	
☐ Drug abuse	
☐ Family member previous mental health or substance abuse treatment	
☐ Diabetes	
☐ Epilepsy or seizures	
☐ Tuberculosis	
☐ Heart problems	
☐ Asthma or breathing difficulty	
☐ Anemia or blood disease	
☐ Cancer	
☐ Other serious illnesses	
☐ Family member disability	

30. Has child received mental health services in past? Yes No If yes, please list:

APPROXIMATE DATES OF SERVICE	TYPE OF SERVICE (e.g., Outpatient Counseling home visits, Inpatient hospitalization)	AGENCY	REASONS FOR TREATMENT

CHILD'S NAME____ DOB___________________________________

*** FOR OFFICE USE ONLY *** NURSING RECOMMENDATIONS	
Physical Examinations	
Dental Health	
Immunizations	
Vision Health	
Nutrition *If yes to key questions, refer to a nutritional specialist*	
Advance Directives *If yes to #28, medical to note for inclusion in Diagnostic Assessment and medical to advise Outpatient Program Mgr*	
Other Medical	
	________________________________ Reviewing Nurse's Signature ______________ /Date

** [__] Reviewed nursing recommendations. _______________ (Therapist initials)